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Author's reply

We agree with Robbert Duvivier's comment that both quantity and quality issues should be emphasised in the education of health professionals. Several educational measures have been taken by the Chinese Government to improve the competence of health professionals. In 2008, a draft standard for undergraduate medical education was announced and implemented by the Ministry of Education (MOE) and Ministry of Health, laying the basis for accreditation of medical schools. All undergraduate clinical programmes in the country are planned to be accredited by 2020. In the 1990s, the government also established national licensing examinations for physicians and nurses. Health professional graduates can provide health services after passing the licensing examinations. Furthermore, the MOE developed infrastructure and faculty criteria for higher education. However, noncompliance with these criteria is common because of insufficient supervision and regulation.

We also agree with Duvivier that improved data are essential. Many governmental departments have introduced an information publication scheme—eg, electronic copies of some statistical yearbooks are available on governmental websites free of charge, and citizens can apply to access information. Nevertheless, more measures are needed to improve the information publication scheme. Some

data, such as pass rates and test scores for licensing examinations are still confidential, although they can be easily obtained by the public in many other countries. The main reason that these records have never been made publicly available seems to be that because it has never been done, the authority in charge of licensing examinations is reluctant to be the first to release their records. The barriers can also come from local authorities or education institutions. For example, few universities or colleges make their financial information publicly available despite being requested to do so by the MOE. Generally, it seems easier to make aggregate data publicly available than disaggregate data. As to the MOE datasets used for our Review,¹ time is needed to explore the possibility of making them publicly available because they contain detailed information for each higher medical education institution.

With respect to nursing education, we share Fengxia Liu and colleagues' concerns. Studies show that about 70–80% of medical disputes were caused by poor communication between health professionals and patients.^{2,3} Therefore, we re-emphasise the urgent need to strengthen training for communication skills in the education of health professionals in China. Violence against health professionals could be reduced by enhancing trust and enabling systematic reforms.

We declare no competing interests.

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Transgender patients need better protection in China

A rough estimate put the number of transgender people in China to 400 000,¹ yet data from the two main centres for sex reassignment (Changzheng Hospital and Shanghai Ninth People's Hospital) suggest that less than 800 transgender patients have been treated in the past 30 years. Therefore, a proportion of transgender patients might have gone to clinics where sex reassignment surgery is not strictly regulated and incur high costs. Driven by profit, some surgeons operate unscrupulously. Moreover, when unable to afford the high price, some patients will turn to unqualified practitioners or travel abroad for cheaper services. Such situations can have terrible consequences for the patients.^{2,3}

To tackle these issues, the Chinese Ministry of Health has provided guidelines: Technical Management Specifications for Sex Reassignment Surgery, in 2009.⁴ The guidelines require that sex reassignment surgery should be done only in third-level, grade-A or plastic-surgery hospitals by senior plastic surgeons. However, the number of surgeries, particularly the less complicated male-to-female operation, continues to decrease in state-owned hospitals.

Despite good intentions, the regulation⁴ might need substantial revision. First, the prerequisites for sex-reassignment surgery seem too demanding. The patient must get approval from direct relatives, obtain a clear criminal record from the local public security office, and have the documents notarised. These rules have raised criticisms about infringement on individual autonomy and privacy⁵ and might contribute to patients seeking care outside regulated centres. Second, the regulation fails to follow



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the prevailing guidelines.⁶ The regulation does not mention the need for hormonal therapy. And the statement⁴ that any operation that changes gender-linked traits shall be done in synchronisation with or subsequent to gonadectomy is medically questionable. Third, the present regulation does not specify penalties for possible violations, which could encourage violation.

In view of these flaws in the present regulation,⁴ future regulations on sex reassignment surgery should be aimed at health promotion rather than mere management, and more humane and meticulous thinking.

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Austerity and its consequences on cancer screening in Greece

On Aug 18, 2014, the Greek Department of Health decided to control the number of presymptomatic checks for uterus, breast, and prostate cancers prescribed by doctors of the Greek National Organization for the Provision of Health Care Services.¹ These checks were restricted by an upper limit to prescribed exams, which varied per medical specialty and exam category; an upper limit of expenditure per physician, which varied according to prefecture and specialty; and prohibition of certain medical specialties to prescribe at all. The argument for these new budget cuts is the necessity to control health-care costs. However, the population in Greece receiving screening services compared with that recommended by the European Council is already low.²

Greece has both non-population-based³ and non-systematic⁴ screening programmes. In countries with organised screening programmes, participation rates in Pap testing are up to 80% (eg, Sweden, Finland, and the UK),⁵ whereas in Greece, participation is less than 60%.² Concerning mammography, less than 50% of women aged 50–69 years in Greece have been screened within the past 3 years,³ whereas European guidelines suggest a desirable target screening rate of at least 75% of eligible women.⁴ This target would be met if more than 1.6 million women aged 40–69 years were screened (women aged 40–69 years in Greece exceeds 2.2 million).⁶

Such unilateral policies without strengthened prevention actions and enhanced participation in presymptomatic exams will increase cancer cases in the near future. These policies will also disproportionately increase social security expenses—the cost of cancer treatment has been

estimated in Greece to be 6.5% of the total health-care expense, largely due to hospitalisations, surgical interventions, and expensive drugs.⁴

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Department of Error

Stoop D, Cobo A, Silber S. Fertility preservation for age-related fertility decline. *Lancet* 2014; **384**: 1311–19. In this Series paper, the number of livebirths cited in tables 2 and 3 and the total number of babies born after cryopreserved ovarian tissue grafting should have been cited as 37 rather than 35 in the Summary, Introduction and Clinical outcomes sections. Additionally, references 87 and 88 should not have been cited in the third sentence of this paragraph. Data in the tables were incorrectly attributed to published references; this information was gathered by Dr Silber by telephone survey of the investigators in October, 2013. These corrections have been made to the online version as of Dec 12, 2014.